



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
STATE TECHNICAL ASSISTANCE TEAM  
CHILD FATALITY REVIEW PROGRAM

**AUTOPSY INVOICE**

**INSTRUCTIONS**

This form must be completed in its entirety for each case in order for you to receive payment. Incomplete forms will be returned. Please send invoice and complete autopsy report to the address below:

**Department of Social Services  
State Technical Assistance Team  
Child Fatality Review Program  
PO Box 208  
Jefferson City, MO 65102-0208**

PATHOLOGIST NAME	CONTRACT NUMBER	TODAY'S DATE
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ADDRESS	DATE SERVICE PERFORMED
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**CHILD/VICTIM INFORMATION**

NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	DATE OF DEATH (M/D/Y)
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DCN (MEDICAID NUMBER)	AUTOPSY CASE NUMBER
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**HEAD OF HOUSEHOLD INFORMATION**

NAME (LAST, FIRST, MIDDLE INITIAL)
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DCN (MEDICAID NUMBER)	SOCIAL SECURITY NUMBER
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COUNTY SERVICE PERFORM FOR	AT A RATE OF \$
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By signing this document, I certify that I have provided consulting services to the Department of Social Services, State Technical Assistance Team and request reimbursement for those services as outlined above.

CONTRACTOR SIGNATURE

